WOMAN TO WOMAN OB/GYN

Suzanne Greenidge, M.D., FACOG ~ Rohana Motley, M.D.
1020 North Broadway, Yonkers, NY 10701 ~ (914) 375-2800 ~ (914) 375-7329
3765 Riverdale Avenue, Bronx, NY 10463 ~ (718) 543-2929
OBSUZIE@aol.com

PATIENT INFORMATION

LAST NAME:________________ FIRST:________________

ADDRESS:________________ APT:_____ CITY:________________ ST:_____ ZIP:__________

HOME PHONE: (____)________________ WORK PHONE: (____)________________ PAGER/CELL(____)________________

DATE OF BIRTH:________________ AGE:_______ SOCIAL SECURITY #:________________

EMPLOYER:________________ OCCUPATION:________________

MARITAL STATUS: S M D W SPOUSE NAME:________________ SPOUSE SOCIAL ________________

SPOUSE'S WORK #: ________________ YOUR E-MAIL ADDRESS: ________________

MOTHER'S NAME:________________ FATHER'S NAME:________________

REFERRAL INFORMATION (Who referred you to us?)

PRIMARY M.D. NAME: ________________ PHONE: ________________ FAX________________

WHO REFERRED YOU? ________________ THEIR PHONE: ________________

EMERGENCY INFORMATION (In case of emergency, who should we notify?)

NAME:________________ PHONE:(____)________________ RELATIONSHIP:________________

PRIMARY INSURANCE INFORMATION:

TYPE OF PLAN: (circle 1)HMO PPO EPO POS OTHER (describe) ________________

INSURANCE NAME:________________ PHONE: (_____) ________________

ADDRESS TO SEND CLAIMS:________________

POLICY NUMBER:________________ GROUP NUMBER:________________

IS WRITTEN REFERRAL REQUIRED? Y N REFERRAL #: ________________

CO-PAY REQUIRED? Y N AMOUNT: $_________ OUT OF NETWORK BENEFITS? Y N

POLICY HOLDER'S NAME:________________ RELATIONSHIP:________________

DATE OF BIRTH:________________ SOCIAL SECURITY #: ________________ EMPLOYER:________________

SECONDARY INSURANCE INFORMATION

INSURANCE NAME:________________ PHONE: (_______)________________

ADDRESS TO SEND CLAIMS:________________

POLICY NUMBER:________________ GROUP NUMBER:________________

IF YOU DO NOT HAVE INSURANCE COVERAGE, FEES ARE $190 FOR NEW GYN, $90 FOR FOLLOW-UPS, & $300 FOR 1ST OB VISIT. THIS IS DUE BEFORE SEEING THE PHYSICIAN. WE ACCEPT CASH & CHECK PAYMENTS. IF YOUR INSURANCE ASSIGNMENT IS NOT ACCEPTED, YOUR PORTION OF THE FEE MUST BE PAID PRIOR TO DELIVERY, SURGERY, OR OTHER SERVICES PROVIDED. IF YOUR INSURANCE COMPANY SENDS THE CHECK TO YOU, YOU ARE RESPONSIBLE FOR FORWARDING THE PAYMENT DIRECTLY TO THIS OFFICE. IF YOU HAVE A CO-PAYMENT YOU MUST PAY AT THE TIME SERVICES ARE RENDERED. IF SERVICES REQUIRE A REFERRAL, PLEASE PRESENT THE REFERRAL TO THE RECEPTIONIST PRIOR TO SEEING THE PHYSICIAN. BY SIGNING BELOW YOU AGREE THAT YOU HAVE READ THIS DOCUMENT & FULLY UNDERSTAND THE CONTENT. THANK YOU FOR CHOOSING WOMAN TO WOMAN OB/GYN.

PATIENT SIGNATURE:________________ DATE:________________